Minnesota Board of Denistry

Dental Assistant Licensure Application Checklist

You must submit the following documents at the time of application for licensure. Use this checklist to ensure that you have included the required documents. Applications with documents missing or not acceptable will be mailed back to you. NOTE TO NOTARIES: Our Board requires a statement from you, along with your stamp/signature that states: "This is a true copy of the original".

☐ Completed Application Form *(All 5 pages complete)*

☐ Diploma *(Notarized copy)* OR Official Transcript *(Original)* OR Certificate/Letter of graduation *(Original)*

☐ Minnesota State Dental Assisting Exam *(Original or notarized copy, must include both Radiology AND Expanded Duties)*

Information on the Minnesota State Dental Assisting Exam may be found at
http://mn.gov/boards/dentistry/licensure/jurisprudence.jsp

☐ Minnesota Jurisprudence Exam *(Original or notarized copy)*

Information on the Jurisprudence Exam may be found at
http://mn.gov/boards/dentistry/licensure/jurisprudence.jsp

☐ Dental Assisting National Board Exam *(Original or notarized copy of official results (No preliminary results will be accepted), must include General Chairside, Infection Control, and Radiation & Health Safety)*

☐ CPR Card *(Copy, ONLY American Heart Association or American Red Cross healthcare provider courses are acceptable)*

☐ Check or money order payable to the Minnesota Board of Dentistry for the amount listed on Page 1 of the application.

The following items must be included if they apply to you:

☐ Certificate of completion of Minnesota expanded functions education *(Notarized copy of certificate of completion OR Notarized copy of current Dental Assisting National Board (DANB) Certificate if you didn't graduate from an accredited dental assisting program. Required only if expanded functions education was NOT included in application item #6)*

☐ Affidavit of Licensure *(Original document, required only if you are or have been licensed/registered as a dental assistant in another state, Canadian Province, or country)*

☐ Response to disclosure questions *(Required only if you answer Yes to any of questions 13-17)*

If you did NOT graduate from a Minnesota Accredited program AFTER September 2, 2004 and you intend to provide Nitrous Oxide, you must submit the Nitrous Oxide application form.

The Nitrous Oxide Application form can be found on our website under Forms
http://mn.gov/boards/dentistry/forms/

Lic # _____

Issued _____

App # _____

MINNESOTA BOARD OF DENTISTRY
2829 University Avenue SE, Suite 450
Minneapolis, Minnesota 55414
(612) 617-2250 (888) 240-4762
MN Relay Operator for Hearing and Speech Impaired
(800) 627-3529

APPLICATION FOR LICENSURE BY EXAM TO PRACTICE DENTAL ASSISTING

NON REFUNDABLE FEE DUE - $123.00

(Application Fee $55.00; Background Check Fee $32.00; Initial Fee $36.00)

Instructions. Each item on this application must be answered fully, truthfully, and accurately by the applicant. Fraud or deception in securing a license is a gross misdemeanor and cause for revocation or suspension of a license. If space for any answer is insufficient, the answer may be completed on another piece of paper. Please specify the number of the item, sign it, and attach it to the rest of the application. BE SURE ALL FIVE PAGES OF THIS APPLICATION AND ITS ATTACHMENTS ARE COMPLETED.

Minnesota Government Data Practice Act Notice. This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. In order to be licensed, you must submit all the information requested in this application. The Board will use the information to determine if you meet statutory and rule requirements for licensure. Accordingly, OMISSIONS OR INACCURACIES ARE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed, at which point the data becomes public. "Private" is defined by law as information which is accessible only to: you; the staff and members of the Board; the Board's legal counsel; any person to whom the Board must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications; and to persons you designate. In addition, if the matter of your licensure becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Americans With Disabilities Act. It is the policy of the Minnesota Board of Dentistry to comply with the Americans With Disabilities Act (ADA). The ADA provides, in part, that qualified individuals with disabilities shall not be excluded from participating in or be denied the benefits of any program, service or activity offered by the Minnesota Board of Dentistry. If you require additional information about the Minnesota Board of Dentistry's ADA policy please contact the Minnesota Board of Dentistry's designated ADA coordinator.

*****PLEASE TYPE OR PRINT IN INK*****

BACKGROUND

1.	Name (last, first, middle)		Today's Date
2a.	Mailing Address (street)	City, State, Zip	
2b.	Primary Practice Address (street) (required if employed)	City, State, Zip	
3.	Telephone (include area code) ( )	Email Address (required)	
4.	Sex ❑ Male ❑ Female	Birth date (month, day, year)	Social Security No. _____--_____--_____
5.	Other name(s) by which you are or have been known and reasons for change		

DENTAL ASSISTING EDUCATION

6. Graduates of accredited and/or Minnesota Board-approved programs:

   Dental Assisting School _____

   Location _____ *City, State* Date Completed _____

   - *Attach a **NOTARIZED** copy of your diploma*
     *OR an **ORIGINAL** of either an official transcript or certificate/letter of graduation*

7. Completion of the Minnesota expanded functions education (if not included in item 6):

   Dental Assisting School _____

   Location _____Date Completed _____

   - *ATTACH A NOTARIZED COPY OF YOUR CERTIFICATE OF COMPLETION.*
   - *ATTACH A NOTARIZED COPY OF YOUR CURRENT DENTAL ASSISTING NATIONAL BOARD (DANB) CERTIFICATE IF YOU DID NOT GRADUATE FROM AN ACCREDITED DENTAL ASSISTING PROGRAM.*

EXAMINATIONS – ***All exams must be passed within 5 years prior to application***

Month	Day	Year

8. MINNESOTA STATE DENTAL ASSISTING EXAMINATION - Date Completed
   (Attach an original or notarized copy of Licensure Examination "Pass" letter(s).....

9. MINNESOTA JURISPRUDENCE EXAMINATION - Date Completed
   (Attach an original or notarized copy of proof of passing the Exam) .....

10. DENTAL ASSISTING NATIONAL BOARD EXAMINATION – Date Completed
    (Attach an original or notarized copy of score report card of exams).....

(List other national or state licensure, registration, or certification examinations –
give names and dates of each examination and indicate any failures.)_____

PROFESSIONAL BACKGROUND

11. List each state, Canadian Province or country, where you are or have held a license/registration as a dental assistant. (If so, please complete #12) _____

12.

AFFIDAVIT OF LICENSURE

This Affidavit of Licensure, copy thereof, or official letter that includes this information must be completed by the licensing authority of each state, province and country listed in item 16. The original document, containing an official signature and seal, must be submitted.

I, _____ Secretary/Chair of the _____

_____ hereby certify that _____

was granted license/registration number _____ to practice dental assisting in state/province of _____

on the _____ day of _____, _____, and that this license/registration is: ❑ active ❑ terminated _____.
(date) (month) (year)

I further certify that disciplinary action: ❑ has been taken against said licensee/registrant* ❑ has not been taken against said licensee; **AND** ❑ is pending* ❑ is not pending ❑ that pending disciplinary action cannot be confirmed or denied.

(SEAL)

Dated this _____ day of _____, 20_____.

Signed _____
(Signature of Secretary or Chair)

Title _____

**Please attach a statement pertaining to disciplinary action, if any.*

DISCLOSURE STATEMENTS

	YES	NO
13. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dental assistant or other professional? (*If so, attach a statement indicating reason for action,dates, disposition and address of licensing authority in possession of record.)*	❑	❑
14. Do you have any criminal charges pending against you? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
15. Have you ever been convicted of a felony, gross misdemeanor or misdemeanor? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
16. Are there any unsatisfied judgments against you that resulted from the practice of dental assisting? *(If so, attach a statement giving details including nature of judgment, dates and reasons for non-payment.)*	❑	❑

YES NO

17. Based on your assessment or that of another professional, does your use of alcohol or drugs, or the existence of a physiological or psychological medical condition, in any way impair or limit your ability to practice dental assisting with reasonable skill and safety? (If yes, answer items 1 and 2, below.) ❑ ❑

If yes, please 1) explain the use or medical condition, and 2) explain whether the impairment(s) or limitation(s) caused by your use of alcohol or drugs or by the existence of your physiological or psychological medical condition are reduced or ameliorated because you receive ongoing treatment or because of the manner in which you have chosen to practice. *(Please provide these explanations on a separate attachment to your application.)*

18. **TESTIMONIALS - FROM PERSONS WITH WHOM YOU ARE ACQUAINTED (for at least one year) BUT NOT RELATED (two required):**

This certifies that I have been personally acquainted with *Print Applicant's Name Here* _____ for *# Years* _____ years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure as a dental assistant in Minnesota.

Acquaintance's Name _____Address _____

City _____ State _____ Zip _____

Phone number __(_____)_____

_____
(Acquaintance's Original Signature) ***(Date)***

This certifies that I have been personally acquainted with *Print Applicant's Name Here* _____ for *# Years* _____ years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure as a dental assistant in Minnesota.

Acquaintance's Name _____Address _____

City _____ State _____ Zip _____

Phone number __(_____)_____

_____
(Acquaintance's Original Signature) ***(Date)***

19. **PHOTOGRAPH**

For identification purposes, please tape one passport size photograph here, taken within the last 6 months.

20.

AFFIDAVIT OF APPLICANT

STATE OF and COUNTY OF spaces are for the Notary Public to complete.
You will be asked to write and sign your name in the spaces provide in the presence of a notary public.

STATE OF _____)
COUNTY OF _____) ss.

I, _____, the applicant being first duly sworn, certify that I am the person referred to in this application for licensure as a dental assistant in Minnesota, that under penalty of perjury all the information contained in this application and in any attachment or additional document submitted herewith is true and correct and that all persons and organizations, whether public or private, are authorized to release to the Minnesota Board of Dentistry any information, files or records requested in connection with this application.

APPLICANT'S ORIGINAL SIGNATURE _____
(Sign before a Notary Public)

Sworn to before me this _____ day of _____, 20 ____

My Commission expires _____ *(SEAL)*

_____
Notary Public Signature

NOTES – PLEASE READ CAREFULLY:

a. Please be sure all FOUR pages of this application are completely filled out. Incomplete applications WILL be returned to you without action pursuant to Minnesota Rule 3100.1500.

b. Remember to attach the required original documents or NOTARIZED copies listed in items 6, 7, 8, 9 and 10, when applicable. *(A notarized copy is a photocopy that is certified to be a true copy of the original document and is signed and stamped/sealed by a notary public.)*

c. Include a **photocopy of current BLS Healthcare Provider certification** through AHA or ARC.

d. You may contact the Board office for exam information and an application and schedule to take the Minnesota Jurisprudence exam (Item 9).

e. Your check or money order in the amount listed on page 1 of this applications should be payable to the **Minnesota Board of Dentistry**. Pursuant to Minnesota Statutes Section 604.113, there will be a $20 service charge on all checks not honored by your bank.

f. Please review the checklist below before you submit it to the Board.

APPLICATION CHECKLIST

Items to include with application:

- ❑ Submit notarized proof of graduation (item 6).
- ❑ Submit notarized proof of passing the Minnesota Licensure Examination (item 8).
- ❑ Successfully complete the Minnesota Jurisprudence Examination (item 9) and submit notarized proof of passing this exam.
- ❑ Submit notarized proof of passing the Dental Assisting National Board (item 10).
- ❑ Tape a passport size photograph from the past six months to this application (item 19).
- ❑ Submit the application fee (by check or money order only)
- ❑ Submit this *completed* application for licensure
- ❑ Photocopy of current AHA or ARC Healthcare provider BLS certification

APPLICANT NOTES – Use this section to add to or correct any answers on your application.

Question Number Answer

_ OFFICE USE BELOW _

____ CERT. ____	____ PHOTO ____	____ TESTIM. ____
____ LI. EX. ____	____ DIPLOMA ____	____ CPR ____
____ JURIS. ____	____ MONEY ____	____ AFFID. ____

OTHER:

_____

10-1-2016